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2nd Session
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Wednesday 15 November 2017

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STANDING COMMITTEE ON ESTIMATES

Wednesday 15 November 2017

ASSEMBLÉE LÉGISLATIVE DE L'ONTARIO

COMITÉ PERMANENT DES BUDGETS DES DÉPENSES

Mercredi 15 novembre 2017

The committee met at 1547 in room 151.

MINISTRY OF HEALTH AND LONG-TERM CARE

The Chair (Ms. Cheri DiNovo): Good afternoon. I apologize for my voice; I need some health from the Ministry of Health this afternoon.

It's our last afternoon together. We are going to resume consideration of vote 1401 of the estimates of the Ministry of Health and Long-Term Care. There is a total of four hours and 58 minutes remaining; however, we finish this afternoon.

Before we resume consideration of the estimates, if there are any inquiries from the previous meetings that the minister has responses to, perhaps the information can be distributed by the Clerk. Are there any items, Minister?

Hon. Eric Hoskins: No, there are not.

The Chair (Ms. Cheri DiNovo): When the committee last adjourned, the government caucus had five minutes remaining in their rotation. Madame Des Rosiers.

M^me^ Nathalie Des Rosiers: Minister, I'd like to talk a little bit about the nursing profession in Ontario. I think we all understand the importance of the nursing profession for our health care system. We also know that it's particularly crucial to leverage to the fullest the expertise of all actors in the system. Therefore, I'm very happy to note that the number of nurses who are employed in nursing in Ontario continues to grow.

I understand that in 2016 we saw another increase in the number of nurses in Ontario, for the 12th consecutive year, and that there are now approximately 140,000 nurses employed in nursing. That's an increase of about 2,600 from 2015.

Certainly, I think we can see that they are an important part of the strategy of the ministry. I understand that it's crucial to continue to support the nursing profession. Since they play such a vital role in our health care, what is the government and what is the ministry continuing to do to support nursing and the nurses in the province?

Hon. Eric Hoskins: Thank you very much for that question. I know I only have a few minutes to speak on this important issue.

You're right: When we came into office in 2003, we made a very strong commitment to those in the nursing profession to augment their numbers. We have done that significantly. There are now 28,000, almost 29,000, more nurses that have begun work in Ontario than were working in 2003, and importantly, 11,000 of those, roughly, are RNs. We have increased the numbers of our nurses every year since being in office. That's a proud record, but it also reflects our belief as a government in the health care team and the fundamental and critically important role that nurses play, whether that is in the hospital environment, in primary care, in public health, in cancer care—right across the board—in leadership positions and in administrative positions as well, of course.

We also made a commitment to increase the percentage of nurses who are employed full-time, understanding that that's important for a whole variety of reasons. It's best for nurses themselves, obviously, in terms of having that sustainability and the benefits that come with a full-time position, but also, I think, it makes for a stronger workforce overall. So we have worked diligently on both of those.

As well, we've been working to expand the scope, so we are working with the College of Nurses with regard to our RNs for independent prescribing, and again with the college for nurse practitioners for them to be able to prescribe controlled drugs and substances. We started and created the first nurse practitioner-led clinic, the first of 25—the first, actually, in Sudbury—which is such a valuable resource. The satisfaction that we find from clients, as their primary caregivers in primary care are nurse practitioners through nurse practitioner-led clinics—there is an extraordinarily high level of satisfaction, let alone the positive outcomes that come with that type of resource.

We also have focused over the past couple of years, as is reflected in our last two budgets, to address the issue of recruitment and retention for a variety of health care professionals, but including nurse practitioners, RNs and others that work within our health care system.

M^me^ Nathalie Des Rosiers: What does it mean to say that we're working on retention?

The Chair (Ms. Cheri DiNovo): Minister, you've got 30 seconds.

Hon. Eric Hoskins: Often, in the different parts of the health care system, there can be a different level of compensation for, say, nurse practitioners, dietitians, occupational therapists and others. This is to ensure that they are being compensated at the appropriate rate reflecting their talents and their contributions. We've in-

vested quite a significant amount, over $100 million over the next three years, to actually increase the compensation for nurse practitioners and other allied health professionals that work in comprehensive team environments. There's a lot more work to be done, but it has been a priority of this government and will continue to be a priority of this government.

The Chair (Ms. Cheri DiNovo): And that is it. We now move to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Good afternoon, Minister. Going back to the Auditor General's report from 2016, in March, the Auditor General found that a year after its deadline passed, seven core projects managed by eHealth were still within budget but only 80% complete. Have those projects, since then, been completed within the $1-billion budget?

Dr. Bob Bell: So I'll perhaps start responding to that, if I may, Minister. Is that okay?

The Auditor General's report was useful for us with respect to digital health last year, Mr. Yurek.

I'll ask Greg Hein, our acting ADM for the Digital Health Secretariat, to talk about those projects, most of which have been completed and closed off.

The exciting thing that we learned last year was that in the last couple of years, we've actually been achieving more benefit from investments made in digital health that is based on patient satisfaction but, importantly, based on reduction in cost to the health care system, reductions in issues like patients travelling on northern health travel grants—instead of that, using telemedicine—and reductions in costs from patients receiving home care through telehomecare. We started to see a net savings to the health care system from digital health investments.

I'll ask Mr. Hein to comment on the projects that were noted as being incomplete by the Auditor General.

Mr. Greg Hein: Greg Hein, interim ADM of digital health.

Dr. Bob Bell: You've been demoted from yesterday; yesterday it was acting deputy.

Mr. Greg Hein: We'll see what happens next year.

I said yesterday—and it was the case—that we had a really good, productive discussion with the auditor. At that time, there were a few projects that were nearing completion; they have since neared completion. One of them is the diagnostic imaging system. There's a common services layer now that is in place that allows for sharing of diagnostic images across the province.

In some cases, there was a delay in finalizing a project—the lab information system is a good one—because we held it back. Here's an example of why: A hospital would be renewing its hospital information system, which is a fairly expensive undertaking. Instead of using tax dollars to hook up the lab information system to that hospital, we agreed with the agency to delay that, because we thought it was a bad use of tax dollars. Since the auditor's report, all of the projects have been "closed out," which is the technical term with those who oversee I&IT projects.

The other way to look at it—when it comes to ConnectingOntario, which the deputy talked about yesterday—is that it's like a version of a BlackBerry or an iPhone. It's in place; there are a 100,000 users of it—24,000 active users. It will continue to be improved over time, but, much like a device is, on a version basis.

Dr. Bob Bell: You might mention the DHDR as well, Greg—coming into the ConnectingOntario ClinicalConnect environment this year.

Mr. Greg Hein: Yes. That's one of the amazing developments, truly, in an evidence-based way, that clinicians always wanted—both immunization and drug information through ConnectingOntario. Frankly, use of that asset was middling until that was introduced. Now the active use of ConnectingOntario is increasing, as it is in ClinicalConnect, the asset used in southwest Ontario.

Dr. Bob Bell: I believe the Auditor General last year described the Digital Health Drug Repository as being a delayed project, and that has been closed out, is operational and is also providing narcotic information to all practitioners.

Mr. Greg Hein: The electronic health record is in place and delivering value.

Mr. Jeff Yurek: Is the drug information system on track to be completed by March 2020?

Dr. Bob Bell: That's the electronic health drug repository that we were talking about.

Mr. Jeff Yurek: Was that the repository?

Dr. Bob Bell: Yes. The other thing is PrescribeIT, that may have raised tension. PrescribeIT is an investment they made by Canada Health Infoway across the country, which had its first transmission of a prescription in our province about two months ago in Huntsville, I believe, and is progressively rolling out, sending electronic prescriptions from primary care EMRs to pharmacy workflow programs. That's the other part of the drug system that we're excited about seeing evolve.

Mr. Jeff Yurek: Do you have a total cost or an estimate of what the total cost will be for the entire eHealth project?

Mr. Greg Hein: As the deputy and minister said yesterday, the direct expenditures that come from the Digital Health Secretariat for digital health is just under $500 million on an annualized basis. There is also some indirect spending that goes to LHINs and others and then on to hospitals for their front-line systems. You could break it down into its component parts, but, essentially, that is the amount for our whole range of digital health activities on an annualized basis.

Hon. Eric Hoskins: If I can just add as well: In the context of that expenditure, Canada Health Infoway also estimated that our annual benefit for that investment is in the order of $900 million a year, and then Ed Clark, in his report, which, together with the AG's report, has formed the basis for our own 10-point plan and strategy, estimated the value of eHealth investments to date being in excess of $5.7 billion.

Mr. Jeff Yurek: Okay. Thank you.

Just going on to another part; I'm probably done with eHealth.

A 2016 report found that wait times for patients to receive treatment, especially at psychiatric facilities, were getting longer and longer.

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In 2015-16, children had to wait more than three months to receive help for severe eating disorders at Ontario Shores. The wait-list for one of the main outpatient programs was so long in 2015-16 that the hospital temporarily stopped adding new people to the wait-list. Patients with borderline personality disorders waited for about a month and a half in 2011-12 for a program at Ontario Shores; in 2015-16, they had to wait seven months.

Have you been able to improve the wait times for these programs? If so, what are they at now?

Hon. Eric Hoskins: I suspect that we're going to have an individual from the ministry who can speak to this in more detail in a moment.

Our annual investment to support individuals with eating disorders and to provide the relevant treatment services is in the order of $28 million a year.

We have substantially increased the capacity, particularly at Ontario Shores, with the creation of the first inpatient service specifically for children and youth with eating disorders. I can't remember precisely the number of beds.

Dr. Bob Bell: It's 22.

Hon. Eric Hoskins: There are 22 beds at Ontario Shores, and it looks like we have 90 beds province-wide that are dedicated to those with eating disorders.

Dr. Bob Bell: That's mental health beds in total, Minister. Sorry. It's 90 new mental health beds across the province that are committed to currently.

Hon. Eric Hoskins: So of the roughly 1,200 acute-care beds that were announced by the government several weeks ago, 90 of those are specific to mental health acute care—

Dr. Bob Bell: And those are all base investments, Mr. Yurek. They're not surge per se. They aren't anticipated to go up and down.

Hon. Eric Hoskins: I'm sorry; it's a 12-bed multidisciplinary residential treatment program for children and adolescents between 12 and 17—for those individuals with eating disorders. That's the Ontario Shores program, where, on an annual basis—this year, for example, we're investing $4 million in that program.

Mr. Jeff Yurek: Have you figured out if the wait times have been improving?

Dr. Bob Bell: The wait time figures you quoted are accurate, as the Auditor General found. We're anticipating that these investments in mental health beds will help improve that. We haven't seen the impact of these beds to date, I think it's fair to say. They're just opening now.

Mr. Jeff Yurek: The report also found that there were no provincial mental health standards, so each hospital created their own standards for admission, treatment and discharge, which resulted in different treatment outcomes for patients. One hospital reported that they had referred the same patient to two specialty psychiatric hospitals and the patient met the admission standards at one but was rejected at the other.

Do you have any plans to develop provincial mental health standards to ensure equitable mental health care across the province?

Dr. Bob Bell: I'll start off by introducing Mr. Dicerni, the ADM who has responsibility for the mental health portfolio, and mentioning that one of the recommendations of the minister's mental health leadership council is indeed to evolve quality standards for mental health in the same way that standards for general health purposes have become standardized across the province, partly through Health Quality Ontario. I think this is one of the strong recommendations that we're looking at implementing now.

Patrick?

Mr. Patrick Dicerni: Patrick Dicerni, assistant deputy minister in the policy and strategy area of the ministry.

Thank you for the question, Mr. Yurek.

As the deputy mentioned, working closely with partners in the ministry and HQO—Health Quality Ontario, over the last couple of years, has been developing clinical care standards to be embedded into the system in the areas of major depression, schizophrenia and anxiety, as an element of the work that we've been doing with our mental health and addictions leadership council—increasing the adoption and standardization in terms of the uptake around those quality standards.

Mr. Jeff Yurek: I've been getting some sporadic calls and emails—some doctors are having a hard time accessing the flu vaccine. Have you noted any issues at the ministry?

Hon. Eric Hoskins: I haven't heard anything. Can anybody from the ministry speak to this?

Ms. Roselle Martino: Roselle Martino, assistant deputy minister of the population and public health division.

I'm sorry, what was the question?

Mr. Jeff Yurek: Have you had any reports of doctors having a tough time getting access to the flu vaccine? I'm getting calls and emails from doctors who say they've been turning patients away because they can't get the vaccine.

Ms. Roselle Martino: No, I can say that there has been no shortage of the flu vaccine at all for the province. All our participating delivery agents, including doctors and pharmacies, would have received their allocation of flu vaccine, and that happens based on what they used last year, and then it's a rolling supply as they request it.

Dr. Bob Bell: We'll certainly check on that.

Mr. Jeff Yurek: Okay. I've had a couple of phone calls, a couple of emails and a few tweets on it, so I just thought I'd follow up on that.

I'm still going to work on immunization. You might want to stay.

Hon. Eric Hoskins: Just as an addition to that, my understanding is we've received 99% of the province's required allocation of flu vaccine already.

Ms. Roselle Martino: Yes, correct. It comes in instalments from Health Canada.

Mr. Jeff Yurek: In the 2014 Auditor General's report on immunization, it identified almost 21,000 instances, during the flu season, of the ministry paying both doctors and pharmacists for administering the vaccine to the same patient. There were also about 11,000 questionable billings, where the same patient was billed more than once by an individual provider. The Auditor General's 2016 follow-up report said that the ministry indicated that it would not be implementing the recommendations from 2014 to disallow duplicate billings by health care providers to administer the flu vaccine.

Is there any reasoning behind that, or have you changed?

Ms. Roselle Martino: I can start, and maybe Patricia can speak to it more. We have explained to the Auditor General, and provided evidence for that, that it wasn't that there were duplicate billings; it's that what was entered were several—it was entered incorrectly. We've been working with our health care providers to reconcile that reporting. That's going to be updated. It's a reconciliation.

Mr. Jeff Yurek: Would you be able to provide an update on the progress since the Auditor General's follow-up report in December 2016 on the ministry's publicly reported immunization rates at daycares and identifying schools with low immunization rates?

Ms. Roselle Martino: We can take that back.

Mr. Jeff Yurek: And improving the collection of information on pharmacists and public health unit staff who administer vaccines associated with adverse effects—are you collecting?

Ms. Roselle Martino: Yes, and we can all take that back.

Mr. Jeff Yurek: Okay. That's it for immunizations.

How many minutes do I have left, Chair?

The Chair (Ms. Cheri DiNovo): Five.

Mr. Jeff Yurek: Five? Good. Let's discuss workplace violence. It has continued to be an issue for Ontario health care workers. A new, recent survey indicates the situation isn't improving: 68% of front-line health care staff surveyed were physically assaulted in the past 12 months, 86% reported they were subject to verbal violence in the same time period, 43% reported experiencing sexual harassment or sexual assault in the past 12 months, and 20% reported having been physically assaulted more than nine times in the same time period.

The OCHU proposed 10 items that would help protect hospital staff from violence, including whistle-blower protection legislation; increasing staff levels in areas where staff are vulnerable to assault; and improvements to reporting between institutions, police and corrections about violent patients. Have you met with OCHU regarding these recommendations, and are they being considered for implementation?

Hon. Eric Hoskins: Yes. They were a member of the workplace violence table that was established, I believe, in September 2015 and has completed phase one of their work that focused, in the first instance, on violence against nurses in hospitals. It was the task force, which is a joint effort between the Ministry of Health and the Ministry of Labour, with the two ministers—myself and Kevin Flynn—responsible as co-chairs or co-leaders of that task force, which is comprised of stakeholders as well as front-line health care workers, the associations that represent them and then other experts that can help us understand what the best practices are and develop a stronger ability to reduce and eventually eliminate workplace violence. It was formed with the premise that everyone going into a workplace, wherever that might be, but including in our hospital environment or in the health care sector should—we have a responsibility to ensure that they feel safe and are safe and go home safe.

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They've completed phase 1 of their work. I think there were approximately two dozen recommendations that came out of that phase 1, and a number of them were accepted by the task force by consensus. The government, through the various ministries, is now in the process of implementing them.

One important measure that we took early on was to issue a directive to hospitals where, through the quality improvement plans of the hospitals, they are now required to report specifically on workplace violence and the measures that they take to reduce and eliminate those risks to health care workers. We've now just begun phase 2 of the task force, which is going to be looking specifically at long-term care. As you know, a similar problem exists for health care workers and providers who work in that environment.

Dr. Bob Bell: The one thing I must inform the minister—I believe that OCHU wasn't represented at the table, but OPSEU was present. The table was co-chaired, actually, by the ONA president, Linda Haslam-Stroud. So those two unions were present at the table.

Mr. Jeff Yurek: Now, you mentioned OPSEU. They had five recommendations; two are pretty low-cost. Have you discussed them further with OPSEU?

Dr. Bob Bell: We've certainly spoken to the vast majority of the recommendations. I don't remember which ones were specific to OPSEU. We had several working groups that provided the table with recommendations. Probably the most impactful in terms of getting the attention of the hospital community was the minister's directive that all hospitals had to include workplace violence reporting as part of their quality improvement plans for next fiscal year.

In terms of OPSEU's specific recommendations, Denise, do you know which those were?

Ms. Denise Cole: In terms of the work—

The Chair (Ms. Cheri DiNovo): Could you introduce yourself?

Ms. Denise Cole: Oh, sorry. Denise Cole, assistant deputy minister, health workforce planning and regulatory affairs with the ministry.

OPSEU had a 10-point plan that was included as part of the overall work that the leadership table was doing. In terms of the way that the leadership table was structured, there was the table that was co-chaired by ONA and the

OHA. It included deputies from the Ministry of Labour as well as both ministers and a number of key partners. There were also working groups that were structured to focus in on specific aspects—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up, Mr. Yurek.

We're going to move now to the third party. Madame Gélinas.

M^me^ France Gélinas: My questions are all over the place, but we'll get through them as best I can. The first one is—the move of the CCACs into the LHINs will bring upon savings. I was wondering, have we started to see those savings? Where will I be able to track this down? Are we on track? And how large or little are they?

Hon. Eric Hoskins: Thank you for that question.

Yes, we have already begun to see those savings. Work continues to be under way to find additional savings, all of which are being invested back in front-line health care—home care.

One of the things that we did prior to the transition was inform our LHINs, as they undertook the responsibilities that had previously been undertaken by our CCACs, that we would be reducing their budgets by 8% with the expectation that that was an accurate reflection of what we believed should be the initial and immediate savings that they would accrue as a result of—

M^me^ France Gélinas: So the CCAC budget went down 8%, or the LHINs'?

Hon. Eric Hoskins: It was the non-front-line care, non-direct-care component of the combined budget, if you will, so representing administrative costs.

You can describe that 8% decrease as sort of baked in on a go-forward basis, so as the transition occurred, the LHINs made the changes necessary to be able to accommodate that reduction in the administrative costs.

M^me^ France Gélinas: Was there any kind of one-time cost? I know in our LHIN they had to change office space and all that kind of stuff to accommodate the move. That came with a cost.

Dr. Bob Bell: As far as I know, in the North East LHIN, they used the existing spaces, the CCAC offices and the LHIN offices, to accommodate all staff. There were roughly 59 senior managers and executives across the province who lost their positions. They were redundant as a result of the integration. So we didn't need more office space; we actually needed a bit less, as part of the savings.

M^me^ France Gélinas: Okay. The 8%: Could you give that to me in a dollar amount?

Hon. Eric Hoskins: That's $10.7 million.

M^me^ France Gélinas: Thank you. And where will I see that this $10.7 million has stayed here and not got—what documents should I look for?

Hon. Eric Hoskins: As I mentioned, those savings were then reinvested directly into front-line home care services.

M^me^ France Gélinas: Okay.

Hon. Eric Hoskins: We would be happy to look into that in terms of precisely where that might be found in a line item—it's easy to find; it was invested—in terms of the document.

M^me^ France Gélinas: Okay, so $10.7 million came out of admin fees and went into front-line services, and I will be able to see this at some point.

Hon. Eric Hoskins: I'll discuss it further with the ministry to see if we can accommodate that.

I should mention, as well, that just prior to the transition this year, there were sort of three separate entities that provided a variety of back-office services to CCACs and to LHINs. Those were merged into a single entity, with opportunity for savings to accrue from that. That work is, of course, under way as well with regard to finding those savings, which will, again, be invested back into direct patient care.

M^me^ France Gélinas: Thank you.

Health links now: There seems to be a different funding model or a different cost associated with different health links models. Am I right, or can somebody shine a light on the different types of health links models and how their financing differs?

Dr. Bob Bell: The health links were started with various phases of health links evolving. We're working to bring those under a consistent funding model in this next year. As you know, the health links are really pretty much overlapping the geography of the LHIN sub-regions. Part of the LHIN responsibility is to ensure that each one of our LHIN sub-regions—there are roughly 76 of these care communities across the province—actually has a functioning health link for complex patients. We'll be harmonizing the funding for those as we do that. In some cases, we've got geography that doesn't exactly overlap, so we'll be shrinking some health links to fit the LHIN sub-region. But that work is well under way.

M^me^ France Gélinas: Do we know what the funding model going forward will look like?

Dr. Bob Bell: I can't describe that immediately, but it will be consistent for all of the health links, depending on both the number of complex care plans they have actually achieved and how many complex patients they are caring for. There will be some relationship to the clinical activity they're undertaking.

M^me^ France Gélinas: Can you give me a time frame?

Dr. Bob Bell: Our director Phil Graham is here. He can describe this harmonization process, since he's in charge of it.

Mr. Phil Graham: Thank you. Phil Graham, director of the primary health care branch, Ministry of Health.

In the funding model, there are a couple of phases involved. First is that the ministry looks at the calculation of complex patients by health links within a LHIN and makes allocation recommendations that way, as well as looking at some equity indicators, such as the proportion of indigenous populations' rurality, as a way of coming up with proportional funding relative to the work that has to be done by each health link.

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We then transfer the funding to the LHINs and they make local determinations based on where a health link is

at in its sort of maturity journey. So a health link that's starting up new will likely be a bit more resource-intensive than one that has been operating for a few years. Every year, depending on where that health link is at in its maturity, there may be minor adjustments that the LHINs make to reflect the level of activity happening in the health links, but it starts with an assessment of the number of complex patients, as well as other indicators that influence the intensity of the work required.

Just this year, we got into a stable funding regime. Previous to this year, funding was done on a one-time basis, which was quite difficult for health links to plan and for LHINs to plan in advance. So we provided a three-year funding window for the health links to ensure somewhat of a predictable funding regime so that they can plan better from one year to the next.

M^me^ France Gélinas: If the LHIN happens to have a surplus, can they use it as they see fit, or do they have to send it back to you if it's specifically money coming for health links?

Mr. Phil Graham: The funding is earmarked specifically to support for complex patients. So if it's not spent on health links, it should be returned to the ministry. I say, however, that as we work to transition, as the deputy said, health links into broader sub-region activity—so improved care coordination and improved connections between providers based on assessment by the ministry—we would enable the LHINs to spend those funds on sub-region coordination of services that may extend beyond complex patients, but by and large it is focused on the health link work.

M^me^ France Gélinas: Okay. Jumping completely—sorry—I'm now going to the Digital Health Strategy. I'm just a little bit curious as to where in the budget I can find how much money is being targeted toward the Digital Health Strategy. I'm interested not only in the billing capacity but looking at skills in community and neighbourhood and consumer health strategy—the whole picture of the Digital Health Strategy.

Hon. Eric Hoskins: Okay. There was $15 million allocated in this year's budget specific to digital health activities, and it covers a variety of activities—an expansion, for example, of some innovations, one known as eReferral and another is eConsult, that have been existing as highly successful pilot projects in individual LHINs. We are expanding those. In addition, you're right to point out the consumer-facing aspect of digital health, which is one area that's been very important to the ministry to invest on the patient- or client-facing aspect of digital records, understanding that that will both empower clients and patients by having access to that information. But, also, it's their medical record, so they're entitled to have access to it. In terms of—

Dr. Bob Bell: It's vote 1403.

Hon. Eric Hoskins: Vote 1403 is the specific area in estimates where you can find more detail presumably—

Dr. Bob Bell: Yes.

Hon. Eric Hoskins: —but I'm sure we can go deeper on this if you'd like us to.

M^me^ France Gélinas: I would like to go just a little deeper, faster—deeper but fast because I have a series of other questions as to whether the $15 million is going to be spent. I'm curious about how much of this will go towards community mental health agencies that really don't have strong and robust data and performance measurements. I'll leave it at that. Can you answer some of that?

Dr. Bob Bell: Go ahead, Greg. Is that okay, Minister?

Hon. Eric Hoskins: Yes.

Dr. Bob Bell: Okay.

Mr. Greg Hein: Again, Greg Hein, interim acting deputy minister of digital health.

The way I would add to what the minister said is there's an extra injection of money for the Digital Health Strategy, but one of the objectives of the strategy is to take the current expenditures, the current systems and maximize their value in a greater fashion, and this includes some community assets. It includes the Community Care Information Management system, and it also includes the CHRIS system that's operated by the new Health Shared Services Ontario, formerly OACCAC. There is an effort to figure out how those community-based solutions work effectively together to support the mental health strategy among others.

Dr. Bob Bell: This is, again, one of the recommendations that we got from the mental health leadership council—that we increase both administrative information and clinical information. We're fortunate to have two clinical systems. One is called OCAN, and the other is called—the addiction system, Patrick?

Mr. Patrick Dicerni: DATIS.

Dr. Bob Bell: DATIS, thank you—that are maintained and have discreet data opportunities. So we may be able to leapfrog here. These systems offer us the ability to collect discreet data about patient clinical information. That would be a big step forward for mental health. That's part of our anticipation of our response to the mental health leadership council's recommendations.

M^me^ France Gélinas: When the leadership council says that they have data infrastructure gaps within the community mental health system—can some of that $15 million be used to fill those infrastructure gaps?

Mr. Greg Hein: A really important part of the mental health strategy is to fill those enabling technology and information management gaps using things like the assessment record system that exists now. People are pretty excited about that potential. Funding is going towards that to fill those gaps.

M^me^ France Gélinas: So the answer to my question is yes?

Hon. Eric Hoskins: Yes—not so much, necessarily, the $15 million that was in this budget. But, as was mentioned, there is an exercise, as part of the strategy, to look at the existing allocation of funds within the overall Digital Health Strategy and ensure that we're targeting the most appropriate investments, including infrastructure, as you mentioned, and getting the best return on investment and meeting the needs that have been iden-

tified by—including others—our leadership council. The opportunity does exist, but I would suggest it exists more within the re-profiling of some of the existing funds that we've been expending.

Mr. Greg Hein: In addition to that, there are other initiatives. In the budget, there was mention of eConsult and eReferral. You mentioned health links previously. There's care coordination, technology-wise. All of those make a contribution to the quality of care in mental health, and there are component funding parts.

M^me^ France Gélinas: Minister, when you talk about opportunities to redirect funds that exist, what size of a pool of funds are we talking about?

Hon. Eric Hoskins: As was referenced, our entire digital health expenditures are in the order of just under half a billion dollars annually.

M^me^ France Gélinas: Five hundred million dollars?

Hon. Eric Hoskins: Yes.

M^me^ France Gélinas: Thank you. I'm jumping, but I have a whole bunch. I'm staying in mental health, but far away from eHealth.

We know that recreational cannabis is about to come on July 1. There is a level of angst within the community mental health system as to how they will respond to the influx of cannabis-related substance users' demands for help. Do we have a strategy and money put aside to increase the resources there?

Hon. Eric Hoskins: We have committed on a number of fronts. Obviously, our concern in the ministry is that of harm reduction. We have embarked upon efforts towards a public education and awareness campaign specifically targeting young persons, but also working with our partners in the health sector, including mental health, to ensure that they have the necessary resources to accommodate any changes or challenges that they might face as a result of the federal decision to legalize on July 1.

M^me^ France Gélinas: Can you give me a monetary amount that is going to this harm reduction education, as well as a monetary amount that is going toward supporting our community mental health?

Hon. Eric Hoskins: We're currently in discussion, together with Cabinet Office and Treasury Board, with regard to a specific allocation.

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M^me^ France Gélinas: Both for the education and harm reduction and the actual—none of this has been—

Hon. Eric Hoskins: We have already begun the work quite some time ago, working across government, quite frankly, on the education and awareness. We are currently, I believe, funding that within the existing envelope.

Dr. Bob Bell: Yes, and I think we've got a new [inaudible] as well in development.

Hon. Eric Hoskins: And we have a cabinet submission we're currently negotiating with regard to additional moneys for that. I would say that, with regard to the medium- and long-term requirements of support to our partners, that is the current discussion that is underway.

M^me^ France Gélinas: I understand. How much will be spent in this fiscal year on harm reduction education?

Dr. Bob Bell: The other player here is, of course, the federal government, who have told us that there is a major commitment to public education related to—

M^me^ France Gélinas: Yet to be seen, yes.

Dr. Bob Bell: —safer use of cannabis products and education around the associated risks. So it is a combination federal-provincial effort.

The Chair (Ms. Cheri DiNovo): Madame Gélinas, you have just over two minutes.

M^me^ France Gélinas: Oh, no.

Can you give me the amount from the provincial government?

Hon. Eric Hoskins: It's $2.5 million this fiscal year.

M^me^ France Gélinas: So $2.5 million? Okay, thank you.

And the money that you have announced to support the opioid crisis: Do you know if we're on track to spend it all in this year?

Hon. Eric Hoskins: So you're referring to the investment now, because there have been several announcements. I think the total expenditure is in the order of $250 million to $275 million over roughly a three-year period. I can't recall the precise number that was allocated to this fiscal year, although I'm confident there are certain elements—for example, with the support of front-line harm reduction workers, there was $21 million that we believed and heard we needed to get out the door in an expedited way, which we did through our LHINs to the agencies and community organizations that are providing that support. That money has flowed. I don't know if there is—Bob?

Dr. Bob Bell: The other comment I can make, Minister, is that our team is meeting on a weekly basis, both with LHINs and with the agencies that are being funded, to ensure—since this is late in the fiscal, the money has gone out. We're ensuring that they're actually having the information from the LHINs about the investment decisions that are being made.

We've also got a standardized process for looking at investments in front-line workers and harm reduction, and the development in each one of our LHINs, if not in each one of our LHIN sub-regions, of rapid access centres for individuals who decide they want information about harm reduction, that being available immediately adjacent to emergency departments or, in some cases, in the hospitals; secondly, investments in community detox beds, the anticipation that each one of our regions will have that; and, finally, the integration of primary care and wraparound mental health services appropriate to the prescription of opioid agonists like suboxone or methadone where appropriate. We're looking at these being—

The Chair (Ms. Cheri DiNovo): I'm afraid your time is up now, Madame Gélinas. We have to move to the government side.

Ms. Kiwala.

Ms. Sophie Kiwala: Thank you, Madam Chair.

Thank you once again for being here today. It is a great pleasure to be here and ask you a few questions on

hospice care and palliative care in Ontario. It is important to me because I have a personal story about hospice.

When I was living in Toronto with my three-month-old and my 18-month-old, I moved back to Kingston to look after my mother, who had been diagnosed with cancer. Her case, because of my circumstances, would have made her an ideal candidate to go into a hospice but, regretfully, there was no residential hospice in Kingston at that time. They are just working on the planning process of building one now. So I'm personally very, very pleased that we are looking at that—that hospices in the province and end-of-life care has a very high priority with this government. I know that it means a lot to individuals in our community. I know, for example, Ron Lirette, the executive director of Hospice Kingston, as well as Allen Prowse, the chair of the hospice's board, are very appreciative of the work that has been done over the last few years with hospices and with end-of-life palliative care.

I just wanted to say that. It's very important to me. It's very important to our community. We've had numerous public meetings and consultations about hospice care. The community is very receptive. I have taken part in some panel discussions on end-of-life care that have been very interesting and, in fact, healing for a community. As communities in the province, we need to talk about end-of-life care more than we do now. It's absolutely one of those guaranteed things in life, and we need to be ready and build the infrastructure for it as our society and community ages.

Again, I'm very pleased that we're committed to supporting high-quality palliative and end-of-life care for all Ontarians who need it. Improving access to palliative and end-of-life care is part of the government's plan to build a better Ontario through its Patients First: Action Plan for Health Care, which provides patients with faster access to the right care, better at-home and community care, information they need to stay healthy and a health care system that's there for future generations. Certainly, the impact of the future generations in Kingston is palpable through the hospice subject. It's also part of Ontario's Patients First: A Roadmap to Strengthen Home and Community Care, which is our government's plan to improve and expand home and community care.

Minister, strengthening palliative and end-of-life care is a priority for our government, to ensure Ontarians can live with dignity and respect in their later years. I know that this meant a lot to me and my family. Thankfully, we were able to manage without that kind of service, but it certainly would have changed our lives dramatically had we had it.

Can you please provide us with an overview on the current status of the ministry's strategy to strengthen palliative and end-of-life care?

Hon. Eric Hoskins: Well, thank you for that important intervention and question. It's a big subject, obviously, and one that I think has become even more necessary as we have a growing and aging population.

As you said, it's inevitable for everyone. We have responsibility as a society, let alone as a government, to provide the highest-quality care and choices available to individuals as they age, so they can age, first of all, as healthy as possible, but when that's no longer possible, to provide them with the necessary support that they can live their remaining days, weeks or months with dignity and in a comfortable environment, in an environment which also demonstrates respect and support to their caregivers, family members and loved ones.

Hospice, as you mentioned, fits deeply into that continuum of care and that myriad of choices that need to be available for end-of-life considerations. But it's not just hospice. Of course, with the federal legislation on medical assistance in dying, we have now drawn that into the discussion about end-of-life care as well—one of a number of choices. We have a responsibility.

At the same time, we've worked very diligently on this as a ministry and as a government to ensure we have the best-possible palliative care, so that individuals who are suffering due to acute or chronic pain—that we have health care providers who are able to provide them with the necessary supports to reduce or hopefully eliminate that discomfort; or, for those who are facing isolation or have mental health challenges at whatever stage of their life, that they're provided with the necessary supports as well at that moment in time when it becomes known or is understood that the amount of time remaining is finite. Even though that period of time might not be known with great accuracy, we have a responsibility, again, as a society to be able to provide those necessary supports and that respect and dignity to elevate that individual as much as possible.

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I'm very proud of the work that we've been doing. I wish John was here, my parliamentary assistant, because back in the winter of 2014, I asked John if he would take on the responsibility of developing our palliative and end-of-life strategy for the government and for the province. He did that and submitted his report in early 2016, I believe, which led to investments in the 2016-17 budget—substantial investments across a variety of areas which, I believe, have already made a highly significant impact with regard to the services and supports that individuals and their families can expect to receive.

We made an investment of $75 million and, outside that, a commitment to create and fund 20 new hospices across the province in terms of their operating costs. Then, more recently—I'm trying to remember the exact date; it was earlier this year—we also announced a capital program of support for hospices so that, understanding—and it varies from community to community, as you can imagine. It can be a tremendous task for a community to fundraise for the capital costs of a hospice. We believed that if we could not only assist with that but also come in very early—obviously, prior to construction, but early in the fundraising process—that it would be, and it has been, a tremendous boost to the fundraising ability of communities to fundraise for the creation and operation of a hospice.

That capital and operating combination, those two elements for supporting hospices, has been highly

successful. In 2016-17, we've created 48 new hospice beds, and 46 in 2017-18, for a total of 94 new beds that have been created since that budget announcement.

I have to say that some of the best engagements and announcements that I've had the honour of participating in—perhaps the best—have been for new hospices or expanded hospices, because it's really quite tremendous, and I know you know this, when you see a community come together. There's so much support for a hospice within a community environment within a region. There are so many people who have volunteered their time, their energy, their passion and compassion to realize that collective dream. For the government to be able to play a small but important role in assisting them in doing that—understanding that that hospice environment is not necessarily for everyone who is approaching and facing end of life, but it certainly is a supportive environment for those who do choose that option.

As I mentioned, there are a whole variety of elements—well articulated in John Fraser's round-table report, by the way. He criss-crossed the province and met with more than 300 stakeholders to assist him in developing the priorities that would end up in his report—priorities both for palliative and end-of-life care.

As I mentioned, there are many elements to the best approach to end-of-life and palliative care. Part of that investment that we're making as a ministry is to provide the funding to train approximately 600 health care providers so that they can meet the palliative care needs of indigenous communities alone—600 health care providers for the express purpose of meeting the unique needs of indigenous communities.

We're also developing new education and training tools for the broader health sector as well, the health care providers, but also to help caregivers to have that knowledge and education so that they can provide the best possible support—that often, as you can imagine, in extremely challenging and trying times, they can then provide that support in the community for as long as is reasonably possible. We're collaborating with Hospice Palliative Care Ontario to do that.

We also, in the last calendar year, launched the Ontario Palliative Care Network, which is a new partnership between the LHINs, Cancer Care Ontario, Health Quality Ontario and a broad range of community representatives. The palliative care network is really responsible for advising the ministry on palliative care, ensuring that we hear the voices and respond to the priorities that are identified by our stakeholders, be they providers or advocacy organizations, caregivers and care partners and others that truly understand what the needs are and what the best practice should be when we think of palliative care.

It is, necessarily, a broad strategy, in the approach that we've taken. As I've briefly referenced, medical assistance in dying has a place among the choices that are available now as a result of the federal decision with regard to end-of-life care. But we're really focused on the individual and are looking, in the context of Patients First, again, but trying to look at the experience and the measures we should take through the lens of the patient—the client—and the caregiver and the care partner.

I think you could say that a related investment that we're making, which will be up and running next year, is Caregiver Ontario, which is a new organization that's being created as a one-stop shop to provide a variety of supports, knowledge and education and access to supports for caregivers, who, we all know—as with, really, pretty well anything when we think of health care but certainly when we're thinking about palliative and end-of-life care for our aging population and more generally—carry a tremendous burden and are absolutely vital to being able to provide the level of support in a dignified manner to that population. So it really is that we have aimed to have a holistic approach to it and tried to improve service integration. We are making sure that we are funding the education of specialists who are knowledgeable and can provide this kind of care and kind of support. We think, as well, that not only do we need to make these investments but we need to do it in a way which is accountable to the public and the individuals that we are working so hard to support.

How many minutes do I have left on this?

The Chair (Ms. Cheri DiNovo): Five.

Hon. Eric Hoskins: I think I can do it. Part of it, as well—and we've come a long way as a society—is that our responsibility as a government is also to increase the dialogue and discussion about palliative and end-of-life. It is, as you referenced, albeit often, if not invariably, tragic and extremely challenging, particularly for the individual and the loved ones, but it's such a natural part of life—with all its variations, but it is a natural part of life. So it's necessary, for a whole variety of reasons, that those discussions happen between family members and loved ones, that there's a clear understanding. Absent those discussions, you won't have necessarily a clear understanding of what the needs, let alone the desires, are of the individuals that we're talking about. It's important that that discussion happen at the earliest possible moment and carry right through to the completion of that segment of a person's life.

As with many things in Ontario, we've evolved a lot. I think it was absolutely necessary that we mature our approach and develop a solid strategy with regard to palliative and end-of-life care and supports. Fortunately, John Fraser, as many of you know, comes at this from very personal experience and is very committed—devoted, I would say, even—to this work. It was a tremendous opportunity. When I sat down with him shortly after he became my PA and I asked him how he felt he could best use his time as PA, knowing that he would be tasked with a million different things, this was the one thing that he felt compelled to do the heavy lifting on.

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The result was, through tremendous consultation and a very open, engaging process—again, as I mentioned, across the province and with hundreds of stakeholders involved: many individuals who are directly involved, like patients, clients, family members, caregivers etc.

To distill from all of that good advice and elaborate his report on the basis of that—it has really, I think, put us as a province and ourselves as a ministry in that right place in understanding what the needs are: the fundamental importance of choice; the underlying necessity of respect and dignity; and needing to work as hard as we can to develop the resources where they're easily accessible throughout the health care system and throughout the province geographically so that individuals and their family members and loved ones can then access those supports when they are needed. As you can imagine, under such trying circumstances—generally speaking—the last thing anyone wants or needs is to have to struggle to access an element of our health care system that is so important to them at that moment in time.

I'll end by saying that fortunately, like so many things—like how we look at mental health today compared to a decade or two decades ago—there is a much greater openness in those discussions about end-of-life care and palliative care. There's a greater openness, I think, to recognizing the vital importance of not only that segment or portion of a person's life but the necessity of building the health care resources around that individual and around their family so that we can enable that individual to exit this life in a dignified fashion.

How am I doing?

The Chair (Ms. Cheri DiNovo): A minute and a bit.

Hon. Eric Hoskins: That's not a filibuster at all; these are all meaningful things, I think.

But Bob is going to jump in here and save the day.

Dr. Bob Bell: I'm not saving the day, Minister.

As a result of the work by the palliative care network, we're starting to see movement in the most important indicator related to this, and that's the proportion of Ontarians who actually end their lives in hospitals. That number has, over the past year, started to go down, which is encouraging, suggesting that folks are choosing either hospice or home as a living place where they can find their family support in ending their lives. I think we're starting to see movement in that indicator, which is very encouraging.

Ms. Sophie Kiwala: We're certainly getting there.

My first introduction to the concept of hospice care was with Casey House in Toronto many, many years ago. I don't know when they started or where the first hospice was in Ontario, but they certainly provided and still provide exemplary care to a very particular community. They did a great job.

Hon. Eric Hoskins: Well, in fact, the Premier and I were just at Casey House a few weeks ago for their grand reopening.

The Chair (Ms. Cheri DiNovo): I'm sorry, Ms. Kiwala. Your time is up.

We now go to the official opposition. Mr. Yurek.

Mr. Jeff Yurek: Minister, on November 7 last week, you announced the building of 5,000 new long-term-care beds over the next four years. Can you inform the committee where these beds will be located?

Hon. Eric Hoskins: You're correct. It was 5,000 new beds over the course of the next four years, as well as a commitment to 30,000 over the next decade.

I'm trying to remember. I spoke to the need to make these beds available in the first instance or as a priority to individuals who are most acutely in need of long-term care, as well as looking at specific or unique communities, be they ethnic or—First Nations indigenous communities, I believe, are referenced, as well, specifically.

I believe it was likely expressed explicitly in the seniors strategy—but to target those parts of the province so that one aspect where those sorts of unique individuals or the specific groupings of individuals, if you will—but the other aspect was, through the capacity planning that we have already conducted on long-term care, to target those parts of the province where the need is greatest.

Then, lastly, I would say that I think it gives us an opportunity, in the case of some redevelopments, to perhaps provide them with the necessary support to either make the business case viable for them or also to protect those homes that perhaps are in smaller communities.

Mr. Jeff Yurek: You've also mentioned that you'll be having the high-dose influenza vaccine next year. How much money have you budgeted for that?

Dr. Bob Bell: I think $17 million—

Hon. Eric Hoskins: It's $17 million annually, right?

Mr. Jeff Yurek: And how many seniors will that vaccinate?

Hon. Eric Hoskins: About 500,000 per year.

Mr. Jeff Yurek: Let's just discuss the Marshall report. There were some recommendations having implications on health care. Have you been working with the Ministry of Finance to review the report and have you had any feedback during the consultation period that you'd like to share with the committee?

Dr. Bob Bell: Yes. Thanks, Mr. Yurek. A lot of the substance in the Marshall report refers to improving care for people who have been injured in automobile accidents. The current system may not be as effective at bringing them back into rehabilitation programs that allow them to return to work.

Some of Mr. Marshall's experience in focusing on better health care outcomes that resulted in better outcomes in the Workplace Safety and Insurance Board really formed the basis for his recommendations in automobile insurance. We're very aware of them. We've recognized the pattern that we've seen with WSIB investments. The idea of fairly intensive case management starting at an early phase of patients who have red flags that they might be having difficulty in getting back to work, for example—early administration of opioids being one example.

The recognition that stratification of risk is an important element of getting people a higher likelihood of returning to work and really taking an opportunity to focus on care, not cash—as an outcome of their accident, not looking at the cash settlement that might be obtained from their "disability" but, rather, trying to limit their disability by getting them back to work.

It's really focused on a rehabilitation approach and really focused on getting expert advice from specialist providers, as well as expert case management as upstream as possible in patients who are recognized as having risks of returning to work.

Mr. Jeff Yurek: Do you have plans to implement the recommendation of moving medical examinations in the auto insurance system into the hospital system?

Dr. Bob Bell: That is a recommendation. I don't think we have concrete plans at the present time, although we are certainly aware of the recommendation.

Mr. Jeff Yurek: Okay.

Dr. Bob Bell: I might say that some of these disability assessment areas of expertise do exist already from the WSIB perspective, so it wouldn't be a de novo investment.

Mr. Jeff Yurek: We've heard from some public health inspectors concerns that they have about being asked to comment on proposed amendments to the Health Protection and Promotion Act, but the amendments themselves have not been made public. Instead, they're asked to make comments on a summary of the proposed amendments. Is this standard protocol for consultation on amendments to regulations?

Ms. Roselle Martino: Roselle Martino, assistant deputy minister of population and public health division.

The amendments, as you know, are posted on the regulatory registry, so that's the formal process. We actually did not remove qualifications of public health inspectors at all. What we have done is, we have made it an accountability requirement of all boards of health to ensure that they hire qualified staff. The qualifications are actually specified in a protocol. Boards of health will be held accountable to that, and it will also enable us to better monitor the practices of boards of health. So the concern for public health inspectors that we're removing the qualification is not accurate.

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Mr. Jeff Yurek: Are you going to expand the consultation time period on these amendments? What we're hearing about and what we're reading about seems to be a summary and not detailed information. Public health inspectors don't understand what they're being asked to comment on.

Ms. Roselle Martino: Right. There's a general 45-day posting period, as you know, but we can also truncate, depending on the time the government has for legislative decision-making.

We have had multiple meetings with a number of different health inspectors and with health inspector groups, and sent multiple clarifications out to them explaining what we're doing, and gave them reassurance. I believe that they do, indeed, now understand what the province was trying to do and that it was actually a good fix for them.

Mr. Jeff Yurek: Thank you. Minister, CBC's Mike Crawley wrote a few articles last week. You may have heard about them. What we've heard back from home care provider agencies and patient groups is a concern about this new PSW agency that you're creating. Their concern is that there are going to be fewer dollars going to front-line home care for patients and they would prefer—"Why isn't he just creating more flexibility and choice in the existing home care set-up?" And the key players feel like they haven't been effectively consulted in the process.

Are you willing to start consulting with those key players as you further develop this role? Will they be consulted?

Hon. Eric Hoskins: Absolutely. We have begun those consultations with stakeholders that have a role to play in the delivery of home care services.

Just cut me off, and it might be sooner rather than later—but it was recommended by Gail Donner in the completion of her home and community care task force work to begin self-directed care. As part of that process, among other things, we looked at other jurisdictions, and we've landed on two models. One is direct financing, where we'll provide the funds to the home care clients to negotiate contracts and to purchase the home care themselves. But there's a subcategory of chronic patients who require more than 14 hours of home care on a weekly basis. We estimate that this model that we're creating may provide opportunity or choice for up to 6,000 or 1% of the total population of those who receive home care.

For this model specifically, we looked to other jurisdictions, particularly in the United States, where I believe there are five or six states that have this model of care where there's an intermediary, if you will, or an agency or an organization that takes that burden away from the client of negotiating contracts and remitting funds—in this case to the Canada Revenue Agency—and other tasks which they are not interested in or would find challenging. By having that entity as an intermediary, the service that we provide to these individuals and their caregivers is to give them the choice of home care provider—the actual individual, say the PSW—and also control over the scheduling of that individual.

It's really about choice and adopting a model that has been successful not just in the United States but in Europe as well and in Australia. We're confident that it's a very small number, relatively speaking, of the home care population that we're talking about, and a specific subgroup. We're confident that this modest investment will yield good results, as it has in other jurisdictions.

Mr. Jeff Yurek: You said the model is in the States. Which states have this model?

Hon. Eric Hoskins: I know that California, Massachusetts, Michigan and Oregon all have established similar authorities or entities. The function that they provide, for example, is contracting for financial management services, maintenance of a registry of available personnel, training of workers, case management etc.—that sort of thing. As well, other jurisdictions around the world have provided that.

Interjection.

Hon. Eric Hoskins: Also, this model of consumer-directed care is available in other states such as Arkansas,

New Jersey, Florida, Vermont, Rhode Island, Pennsylvania, West Virginia, Alabama, Kentucky, Illinois, Michigan, Iowa, Minnesota, Washington and New Mexico. It's a long list.

Mr. Jeff Yurek: It sounds like a song, eh?

Hon. Eric Hoskins: I was taking a breath. There's more. No, I'm just kidding.

Mr. Jeff Yurek: Minister, you have a proposal to amend OHIP regulation 522, changing the prices and rearranging the payment system for community medical lab tests. It was only posted for 15 days for a comment period. Any reason why that was only posted for that short a time?

Dr. Bob Bell: That was the scheduled benefits for a community lab testing—the price paid for various tests. We had undergone an extensive consultation process with the companies that provide community laboratory services. They looked at this. They advised us on whether or not these prices were correct. We had taken their input for quite a long period of time, so we thought that, at this point, the consultation had been undertaken with the key stakeholders who would both be affected by the price change and had been advising us on it. So we thought that a contracted period of regulatory posting was appropriate.

Hon. Eric Hoskins: Yes, my gosh; it's now that I recall the consultation that took place. I know this was in my original mandate letter in 2014. We created an expert panel. We engaged and consulted widely with the sector as well.

The deputy is just seeing if there is anything we can add to that. But we were confident that this was a reasonable approach to take, given the consultation.

Dr. Bob Bell: Any follow-up? We've got somebody with real expertise if you would like other questions, Mr. Yurek, on this.

Mr. Jeff Yurek: Sure. The description on the registry was pretty vague. It wasn't too detailed. Would you be able to table the wording of the proposed regulation 552 amendments at committee?

Dr. Bob Bell: I'll introduce Director Bonnie Reib of our community labs branch.

Ms. Bonnie Reib: Hi. Bonnie Reib, director of labs and genetics. I was busy shuffling up here—if you could please re-ask the question.

Mr. Jeff Yurek: Yes. Will you be able to table the wording of the proposed regulation amendment for 552 at committee?

Ms. Bonnie Reib: Yes—so 552 is changing the opportunity for hospitals to be paid for community work.

Dr. Bob Bell: Maybe I can expand on that while we're sorting out that issue. Especially for areas in the north and rural areas of Ontario that aren't currently served by community labs, what we're thinking about is the fact that they are already providing community lab services, and that they are doing this out of their base hospital budget. What we think about for those communities in the future is funding them for incremental laboratory services they might provide. We haven't actually finalized that. We want to see how many labs are actually interested. In our initial discussions, there is quite a bit of interest in that. Many small communities see this as a risk: that they have to provide increasing amounts of community lab services without incremental funding. And this incremental funding for hospital labs would come from the same pool that we're providing to other community labs. We think this may be an advantage for citizens in rural and northern Ontario, and to do that we'd have to change the regulation.

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Mr. Jeff Yurek: I think I said the wrong number here—522.

Ms. Bonnie Reib: It's 552.

Mr. Jeff Yurek: Five-two-two?

Ms. Bonnie Reib: Five-five-two.

Mr. Jeff Yurek: Five-five-two?

Hon. Eric Hoskins: You're asking about 522.

Anybody?

Dr. Bob Bell: Is that the—

Hon. Eric Hoskins: Which one? Can you describe that again?

Mr. Jeff Yurek: That one is with regard to the prices and rearranging the payment system for community med labs. Would we be able to get the wording at committee?

Dr. Bob Bell: That is the schedule of benefits where we've listed the prices for labs. Is that correct, Bonnie?

Ms. Bonnie Reib: That's correct.

Dr. Bob Bell: Yes. That's why we've had consultation going on for at least two years, regarding the appropriate new prices for laboratory tests.

Mr. Jeff Yurek: Would you share that with committee, the new pricing structure?

Ms. Bonnie Reib: The price list?

Mr. Jeff Yurek: Yes.

Ms. Bonnie Reib: Yes. It will be posted. It's not posted yet.

The Chair (Ms. Cheri DiNovo): Mr. Yurek, you have just over two minutes.

Mr. Jeff Yurek: So many questions to ask. Which ones do you want?

Hon. Eric Hoskins: Take your time. It's a hard decision to make, so I want to give you that time to do it properly.

Mr. Jeff Yurek: With regard to lab services—it's a line item in the estimates. Is there more of a breakdown on what the payments out in the lab community are—the different cost structures?

Dr. Bob Bell: Yes. I can take that.

In the past, we've had prices for each lab test on the schedule of benefits. Those are prices which represent historic costs that have come down pretty dramatically through investments in technology, robotics etc. When we've made the changes that are being proposed, there are a couple of changes we made. One is to reflect the decreased costs of actually undertaking the chemical part of the testing but also to reflect the transportation needs of pre-analytic processing of specimens, which previously was not a separate item.

By doing that, what we're able to do is give a laboratory more money if it's transporting a test from a rural community but the same amount of money for the actual testing component, since these tests are all done in central, highly automated laboratory facilities. We think we're better reflecting both the pre-analytic costs of maintaining a sampling station in a remote area or in downtown Toronto, as well as better reflecting the automation that's inherent in actually doing the test.

These changes have all occurred, and, as I say, they've had lots of input from the community laboratory operators.

The Chair (Ms. Cheri DiNovo): Thirty seconds.

We now move to the third party. Madame Gélinas.

M^me^ France Gélinas: While we're talking about labs: We know that the players in the community lab system are not all created equal. One is humongously big; the others tend to be a lot smaller.

In this new schedule of benefits, do you look at if you give a very high volume of tests to one lab—is it a scaling, or is it that you always get the same amount, no matter if you are a small lab that only does a few and will incur lots of costs or a huge lab that can do the same thing at a way lower cost, simply because the ministry is giving them hundreds of thousands of the same tests to do?

Dr. Bob Bell: I'll start off, perhaps, and just say that this relates to consumer choice. The choice of which lab they go to, of course, determines which company is going to get paid for the test, so there is an element of competition that has entered into the new arrangement in that previously, labs were capped as to the amount that they would receive. That cap reflected a cost structure that was really quite antiquated and antedated the technology assessments that lowered the cost of the average test.

What we're allowing now is for labs to compete for more business. The way they would compete, since the doctor determines the test or the nurse practitioner determines the test, is by offering better service to patients. We think the lab collection stations staying open longer, providing appointments online—these are consumer-responsive changes that the labs are making that we think reflect an interest in competing for business.

M^me^ France Gélinas: So with the lab, the people who use them lots—you've named family physicians and nurse practitioners. All physicians and nurse practitioners, did they have a say as to what the new schedule of benefits was going to be like? And the people like me who don't have a choice—because after I've driven for 45 minutes, I will take the first lab that's there, no matter who it is—were we consulted at all? So were patients consulted, and were physicians and nurse practitioners, to start with those two, consulted?

Dr. Bob Bell: Let me check. I believe that physicians and nurse practitioners were consulted. Bonnie?

Ms. Bonnie Reib: Bonnie Reib, director of labs and genetics.

They were not directly consulted. We had an external consultant who evaluated the prices from across Canada in both private settings and public settings. So when we were looking for value for money, we were looking at actual costing of the tests.

Dr. Bob Bell: Bonnie, didn't Terry Sullivan engage—

Ms. Bonnie Reib: Yes.

Dr. Bob Bell: We did have an expert advisory process as well that certainly did connect with clinicians. I don't know about patients, though.

Ms. Bonnie Reib: So the expert panel connected with clinicians, different physician user groups, all the individual community laboratories, as well as hospitals.

M^me^ France Gélinas: Okay—but not patients. It's funny, because the clinicians are saying that they have not been consulted. So where was—

Hon. Eric Hoskins: The changes that were recommended and implemented were based on the fact that there had been no changes to the level of compensation for individual laboratory tests over, really, a couple of decades in most cases. They reflected through jurisdictional comparisons, understanding the technological advances that had occurred, and in many cases the cost of doing the test was a fraction of what they were being paid. So this really was a recalibration to ensure that, within the overall funding envelope, we were compensating most appropriately for the specific tests that were done.

Then there came from the laboratory sector itself a desire by many to have a greater level of competition, as the deputy had mentioned, for the type, level and nature of the service: to encourage patients, for example, to come to their laboratory site as opposed to a competitor's. But we also built in a two-year transitional period where we created a separate fund which would allow particularly those smaller laboratories, who I have to say were the ones that were encouraging the competitive environment the most, a reasonable period of time so that they could adjust their business practices so they could avail themselves maximally of those changes.

I think this is, really, what we have seen as a result, in terms of the impact on patients, or the impact on clinicians as well, be they nurse practitioners or family doctors. They still have exactly the same opportunity and choice in terms of availing themselves. This was really a recalibration of the level of compensation, reflecting what they should get compensated for tests, given the technological advances.

M^me^ France Gélinas: Okay.

Changing gears now: the title of psychotherapist. We all know we made those changes in 2007. On December 31, 2017, it will now disappear. What do we do with the title of psychotherapist?

Hon. Eric Hoskins: This is an important question, one that I have been very engaged in, particularly in recent months because, as you said, absent an extension, that aspect of the act, because it hasn't yet been brought into force, will effectively cease to exist. So after at least a couple of years, perhaps more, of efforts through the various colleges to come to an agreement on defining the controlled act, in the absence of a consensus, I made a

referral to HPRAC, on an expedited basis, for them to work with the stakeholders and our partners to attempt to reach that consensus and provide advice to the government. I've just now received that advice. I think they provided it on November 1; I just saw it a couple of days ago.

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We are well aware of the deadline, as well, in terms of the necessity to take a decision either with regard to extension or else to be able to post a regulation which we would propose would be the definition.

M^me^ France Gélinas: Will the recommendation from HPRAC be something that will be made public?

Ms. Denise Cole: Denise Cole, assistant deputy minister, health workforce planning and regulatory affairs.

Yes, the report is a report to the minister, and the usual practice is that the report would be made public.

M^me^ France Gélinas: Do you have a time frame for making it public?

Ms. Denise Cole: That would be at the minister's direction, but if I could presume—

Interjection.

Ms. Denise Cole: Since that section of the act expires on December 31, my advice to the minister would be that we make it public before December 31.

M^me^ France Gélinas: Very good. I'll be looking forward to that day.

Ms. Denise Cole: In the RHPA, the definition of the controlled act of psychotherapy is defined. What the colleges who have the controlled act in their current legislation were trying to do is to bring some greater clarity to what the techniques and practices of psychotherapy actually are.

M^me^ France Gélinas: Switching gears completely: I'm looking at the Ministry of Health website—I don't know who's responsible for that—and you really do not have the same amount of resources in French as you do in English. I would encourage you to go to the section of the website that deals with the committee to evaluate drugs, the drug approval process, the formulary—none of this is available in French. You can click on the little "French" button all you want; nothing happens. Even if you go through the French portal of your website and try to access this, you are brought right back to the English part.

Hon. Eric Hoskins: The deputy is checking right now.

M^me^ France Gélinas: You're trying it right now? It won't work.

There are other areas of your website that are not available in French.

Is there any intention of doing that?

Hon. Eric Hoskins: Thank you for pointing that out. It's particularly important because today Bob and I were at the ministry-organized French-language health services forum, which is now an annual event. The French-language commissioner was there, many of the LIHN CEOs were there, the French-language entities were there, and many ministry officials. We now have an ADM responsible specifically for French-language health services.

We'll do our best, as well, but if there are specific elements of the site where you determine there's an issue, please provide us with a list, and we'll rectify it. But we'll go through it ourselves to rectify it.

Dr. Bob Bell: Madame Gélinas, the only thing I can say is that we're really focusing on information being developed on the Ontario.ca/health web page rather than our old gov.on.ca website. If you go there, the French button does work and there is information there that seems to be—

Hon. Eric Hoskins: That might be part of the explanation. I don't think it gets us completely out of this—

Dr. Bob Bell: No, it doesn't.

Hon. Eric Hoskins: We are building, essentially, a new Ontario.ca/health website which is more user-friendly, and we're obviously endeavoring to make sure that that is fully and completely bilingual. But we'll look through the existing site as well to make sure that we're fully compliant.

M^me^ France Gélinas: Okay. Much appreciated.

Basically, your end goal is that everything be available in both languages?

Hon. Eric Hoskins: Yes.

Dr. Bob Bell: Yes.

M^me^ France Gélinas: Okay. Very good.

I'm jumping around. I know that you've given quite an explanation as to the new caregiver agency that is coming forward and their role. I'm more interested in the money that follows this. When does the money start flowing, what does it go to and is any of it flowing this year?

Hon. Eric Hoskins: When you say "caregiver organization," you mean the self-directed care as opposed to Caregiver Ontario? I think we got into this the last time around as well—because I know it can be confusing. I think I announced them both at the same time. This is the one that allows home care clients to choose their PSW?

M^me^ France Gélinas: No, no.

Hon. Eric Hoskins: So Caregiver Ontario?

M^me^ France Gélinas: The new caregiver organization to look—

Hon. Eric Hoskins: Thank you. I was confused.

M^me^ France Gélinas: That's okay.

Hon. Eric Hoskins: Not for the first time.

And you're interested in the flow of money?

M^me^ France Gélinas: Correct.

Hon. Eric Hoskins: The quantum and the timeline.

M^me^ France Gélinas: Yes.

Hon. Eric Hoskins: We anticipate that, this fiscal year, up to $1 million could flow to the organization.

M^me^ France Gélinas: Okay, and is it targeted at setting up the organization, providing services or both, and what is that amount of money going to?

Hon. Eric Hoskins: Both, and I don't have the details beyond that allocation. I'd be happy to talk to the ministry, or—Bob?

Dr. Bob Bell: While the ministry is looking, the anticipation is that this will be regionally developed, so there will be offices not in every LHIN but in every region of the province—and certainly hiring people for those offices who will link together services in the local regions for caregivers in the community, educational services, ensuring that we understand gaps in service that may be present around education of caregivers, making sure that organizations like the Alzheimer Society are linked with local care providers, that people have access to our 96 memory clinics across the province, and that citizens know how they can get access to them. So it's really an integration service of the various educational and support services that are available across the province. It's more integrating access to those services as opposed to providing new services, although some new services will develop in response to the gap analysis that we're expecting to occur.

M^me^ France Gélinas: Okay. So you would not see funding that agency to provide, let's say, respite to a caregiver. Respite would still be going through the LHINs and the home care services—but just linking them up and knowing that, "There is no respite in that area, so we have to work to bring it"?

Hon. Eric Hoskins: Yes, all of the above. They would not provide services directly. It's modelled after a caregiver organization in Nova Scotia. I have to say that since announcing it or even through the consultations, we asked Janet Beed, who is well known within the health sector, to consult widely and come up with recommendations. This was as a result of her recommendations. This has been so well received by both caregivers themselves and the organizations that represent them or interact with them in a variety of ways, including the sorts of organizations that the deputy mentioned.

I'm really excited about this. It's intended to be a one-stop shop for a whole variety of supports in an umbrella organization that really integrates and brings together in a coordinated fashion the supports that need to be available.

M^me^ France Gélinas: And the $1 million is the start-up fund—or is this something you see where these provincial organizations would continue to receive ongoing funding?

Hon. Eric Hoskins: Ongoing.

M^me^ France Gélinas: Of?

Dr. Bob Bell: Up to $3 million a year, planned.

M^me^ France Gélinas: Up to $3 million? One million this year to help them set up?

Hon. Eric Hoskins: Right.

M^me^ France Gélinas: Okay. All right. I'm jumping around.

I know you've introduced some changes to the Smoke-Free Ontario Strategy. The modernization report went way further than what was introduced with the cannabis bill that we saw—made some changes to smoke-free Ontario. What is the amount of money going to smoke-free Ontario, and have there been any changes this year as to the programs, the services? I'm hearing that some of the research that we do in tobacco is about to change and will not be done the same way and not be funded the same way.

Interjection.

Hon. Eric Hoskins: Yes. We have all the answers for you.

M^me^ France Gélinas: She's very good.

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Hon. Eric Hoskins: She's very good.

Dr. Bob Bell: She's excellent, yes. We're very lucky.

Ms. Roselle Martino: Roselle Martino, population and public health division.

Madame Gélinas, the current investment in the Smoke-Free Ontario Strategy is approximately $45 million. We're still putting together the strategy, which is a result of the expert panel that did a report.

The tobacco research is actually—all the funds are staying within the strategy, so we're not removing any money. What we're actually doing is looking at our different agencies and what they have a mandate for. Public Health Ontario does have a mandate to do research, monitoring and surveillance. We'll be looking at identifying which partners should be doing various activities and then working with our other partners to look at other opportunities for funding and projects and evaluation.

We are continuing our relationships. They are not being funded for the same thing, but we are continuing our relationship.

M^me^ France Gélinas: Are we going to come to a point where we have a plan with a specific percentage of smokers, with specific dates and with specific activities to get us to that?

Ms. Roselle Martino: That is the intention, yes.

M^me^ France Gélinas: That is the intention? That's within the $45 million—

The Chair (Ms. Cheri DiNovo): Just two minutes.

M^me^ France Gélinas: Two minutes?

That's within the $45 million that we already have?

Ms. Roselle Martino: Currently—and we'll look at other opportunities as well.

M^me^ France Gélinas: Okay.

I'm going to be looking at wait-time statistics, just if anybody—

Hon. Eric Hoskins: This is the rapid fire coming up, like early warning?

M^me^ France Gélinas: Yes. Sorry about that.

Hon. Eric Hoskins: Just a yes or no for an answer.

M^me^ France Gélinas: Yes.

I will take cataract surgery. There are still long waits for cataract surgery. When we look at cataract surgery priority 4, the target is 182 and the stats say that they are being treated within 96 days.

This has such a huge disconnect with what's going on on the ground that I started to dig and say, "How could it be?" Usually, the stats that come out through the wait times are pretty good. This one doesn't make sense.

What I have found is that you only use the resolved cases. Only the people who have had their surgery are counted—

Dr. Bob Bell: Yes.

M^me^ France Gélinas: That's true?

Dr. Bob Bell: That is true.

M^me^ France Gélinas: Okay—and that 24 hospitals did not report. Is that true also?

Dr. Bob Bell: I don't believe so. Their volume funding for cataracts is dependent on them reporting their wait times. Their wait times are reported by the individual surgeons. The way the hospitals work it is that the surgeon cannot book OR time without reporting the time of decision to the time of surgery.

M^me^ France Gélinas: Are we using a weighted average for a benchmark, or are we using the 90th percentile?

Dr. Bob Bell: We are using the 90th percentile—

The Chair (Ms. Cheri DiNovo): Madame Gélinas, your time is up.

Dr. Bob Bell: We're also—

Hon. Eric Hoskins: The time is up.

The Chair (Ms. Cheri DiNovo): You could continue on on the government side, if you would like.

Dr. Bob Bell: I'll show you the website.

M^me^ France Gélinas: Okay.

The Chair (Ms. Cheri DiNovo): Ms. Hoggarth.

Ms. Ann Hoggarth: Our government is committed to digital health initiatives that lead to better care for patients and contribute to the modernization of Ontario's health system.

Digital health assets help us to improve the safety, quality and integration of health care services, which is why we created a renewed strategy to make our health care system more effective and efficient for Ontarians. I know that at the Royal Victoria Regional Health Centre, CEO Janice Skot and her CFO, Ben Petersen, worked very hard in this regard in particular to make the patients' experience better.

What is the government doing to improve patient outcomes, add value to the health care system, support economic development and drive job creation in Ontario's health technology sector?

Hon. Eric Hoskins: Funny you should mention that. I wasn't aware that Bill was here. One of the best decisions—I really believe this—that we made in government and, certainly, in my ministry was to appoint Bill Charnetski as Ontario's first Chief Health Innovation Strategist. This came as a result of the Ontario Health Innovation Council, leaders in the health sector and the private sector and in innovation and technology, coming up with five recommendations. The one, certainly to me, that was the most important was to create this position within the Ministry of Health, but it serves the Ministry of Research and Innovation as well, and quite frankly, it supports right across government.

I'm going to give pretty well almost the whole time to Bill. Bill and his team have already done, in a short period of time, an extraordinary job at strengthening something which we haven't done nearly well enough, and that's, in the first instance, to recognize and celebrate and champion Ontario innovations, of which there are many. In the health field there are thousands of incredible innovations. There's that, coupled with the reality that, up until recently—and we still have a long way to go—we did kind of a lousy job of adopting those innovations into our own health system.

Bill is tasked with being a liaison to and working with and supporting those innovators to help us build a strong economy when it comes to health care innovation—he's doing just that—and also to work with them to understand how we can do a better job to support those innovations at whatever stage in the innovation cycle they're at, particularly and importantly that aspect of how we can support them through to success and through to adoption in Ontario. It really has been a great addition to the government and to the ministry.

Bill and I just got back from Israel, in fact. We were there on a trade mission as well, looking at digital health and getting a better understanding. We signed a letter of co-operation—an MOU—with one of the biggest HMOs—health maintenance organizations—and the Ontario government and the Ministry of Health to further strengthen the co-operation. His work is really to help the health sector thrive and do better and provide the highest quality care, but also to help our private sector and our innovators thrive in an Ontario context too.

Bill, over to you.

Mr. William Charnetski: Thanks very much. I'll give highlights of what we're up to, then obviously I'm happy to go into detail on anything that you hear.

In September 2015 I was appointed first Chief Health Innovation Strategist, and I really enjoy this job. Part of it is the content, the things you heard the minister describe; part of it is also working with colleagues in one of those situations where everybody agrees on what we should be doing and what the potential is. It's been a real pleasure to have this job.

The minister set out the task. It's exciting that a government in Canada saw the opportunity that lay in investing in Ontario health technology companies, not just to improve patient outcomes and ensure a sustainable health system, but also to create jobs in the province of Ontario.

To that end, the purpose of our office is to drive collaboration across the health system, to accelerate the adoption and diffusion of new innovative health technologies and processes with those three objectives: improve patient outcomes, which, obviously, given our Patients First strategy and given why we all get up in the morning, is the primary goal; at the same time, ensure a sustainable system, we say, by adding value to the system; and creating jobs in Ontario.

It's really that last piece that distinguished us in this role from other efforts, not just in Ontario, but frankly across Canada, where there are literally hundreds of smart, hard-working, passionate people looking at health and innovation.

In Ontario, with the creation of this role, we have that added component of looking at how we could use that investment to create jobs for Ontarians—our kids and grandkids—in an industrial sector that is one of the fastest-growing job creators globally. It has been really

exciting. That fundamental shift, as I said, is what distinguished us from others in Ontario and Canada.

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I used the past tense "distinguished," because if imitation is the sincerest form of flattery, since this office was created, very similar offices were created in both Alberta and Quebec. We have worked with them because our view is that building this innovation receptor capacity across this country is a good thing to do for Canadians, and for Ontarians in particular.

When we took the role, we wanted to ensure that we had impact—again, judging ourselves by those three objectives—so we really focused our priorities, to ensure that we would have impact in our investment of time and money. The five priorities reflect, to a large extent, what the Ontario Health Innovation Council found in their report and the recommendations they made. There are two overarching priorities, and then three priorities where we have chosen to dig deep into our health system.

The first of the two overarching priorities is to optimize the pathways to the adoption and diffusion of innovation. You would think that in an enterprise of this size—$50 billion-plus—that you would have a natural pull of innovation into the system to improve those patient outcomes, and to do so in a most efficient as well as effective way. That's what we want to ensure happens.

The OHIC report said, in particular, that there were barriers and hurdles that existed that were preventing the small and medium-sized companies in Ontario from accessing the Ontario health care system. We have embarked on a couple of measures, with collaboration from our colleagues, to try and remove those hurdles.

Our focus is on Ontario's small and medium-sized companies in this work. You have this $53-billion health system, a single-payer end-user that sits amongst, as I think the MaRS data will tell you, perhaps 1,000 small and medium-sized enterprises in health tech alone that are succeeding on the back, principally, of exports to the United States and western Europe, the Middle East and China. These are strong, vibrant companies.

What we want to do, as you heard the minister describe, is see how our system can help ensure that these companies scale up and stay in Ontario. There is no reason why, for example, the next big multinational health tech company—the next Baxter or Medtronic, if you will—couldn't come out of Ontario, given all the resources, the research facilities, the educational facilities, the government support, the great urban environments that we live in and all the start-up companies that we have.

Having said that, this is not a zero-sum game. It's not looking to grow Ontario's small and medium-sized enterprises at the expense of global companies that are already investing in Ontario and health technology and looking to invest more. Instead, we think about it as growing the innovation receptor capacity—growing the pie, if you will. Our bet is that Ontario's small and medium-sized companies will win their share of that longer list of opportunities, just as they have around the world. That's the exciting part about this. So we see ourselves as a catalyst to grow a healthier health innovation ecosystem within which our Ontario SMEs will survive. That first notion of optimizing the pathways to the adoption and diffusion of innovation is fundamental to that.

The second overarching priority is the shift to value-based procurement in the province, especially in our health sector. In effect, it's to ensure that not only are we getting value for money in our procurement of innovative health technologies and processes and information systems, but that we're also looking at it from a full-value assessment perspective, not simply choosing the lowest-cost item in the time frame, which often ends up costing you more in the broader spectrum. So this shift to value-based procurement is something that is really important to us.

When we look at those two overarching priorities, there are probably three particular initiatives that we're looking at and now executing.

First, on that notion of pathways, we have hired three innovation brokers. This is a new thing for governments in Canada. People have given us all sorts of terrific feedback on what they do. These innovation brokers are field-based people. You, of course, more than anyone else in this room, are familiar with the value that that great constituency assistant will provide to you or that great community outreach person will provide to a not-for-profit organization, for example. That's what we see these folks as doing. What is common amongst innovation brokers, constituency assistants and community outreach people? Insight. It's not just the virtual Rolodex—who a person is or what they are—but, "Why are people doing things? Why aren't they doing things? What would be interesting to them?" Our innovation brokers are looking at health service providers on one hand and putting them together with Ontario's innovators and entrepreneurs so that you've then identified opportunities—problems, if you will—for which our local companies have solutions, and we marry them up. So that example of innovation brokers is something we're doing differently, to really drive this growth in our health innovation ecosystem.

Similarly, MaRS EXCITE is an initiative out of MaRS that streamlines the provision of evidence to those companies that are looking to provide a solution to a particular problem that has been identified in the health system. That is exciting in the sense that—if you think about how a system should work, we should have the demand identified, the priorities identified by the health service provider, and then a call for industry solutions that get matched up together, again, with the outcome of improving patients and ensuring the sustainability of the system while creating jobs in the province. So MaRS EXCITE's value proposition is something that we're looking to evolve to create even more streamlined pathways to the adoption and diffusion of innovation. That is responding to priorities identified by the health system.

The third piece of work out of those two overarching priorities relates to procurement, and that's making sure we are actually effecting that shift of value-based procurement in the things that we are doing in the health sector supply chain while we are also ensuring that our small and medium-sized enterprises have full access and opportunities under the government's broader public service directive and guidelines. With an innovation broker, we are providing enhanced tools and guidance to small and medium-sized enterprises to allow them to take full advantage of the opportunities presented to them in the Ontario health supply chain. We are also providing clarity on what can be done under the procurement directive and guidelines to ensure that opportunities are made fully available to the small and medium-sized enterprises.

The last part of that procurement aspect is the Value-Based Innovation Program, which is really a framework rather than a program. It's a framework for really starting to build the muscle memory within the broader health system on how to use modern procurement techniques to ensure that we are expanding our ability as a health system to adopt and diffuse innovation; that's that innovation receptor capacity I described. That Value-Based Innovation Program framework will be demand-driven. So you will have health service providers identifying the problems for which they believe there are solutions. They'll be using modern procurement techniques—outcomes-based procurement and value-based procurement—to identify those problems and then calling for industry solutions and being matched up. You might say, "Well, what's unusual about that?" So far, not much, but what's really interesting and exciting for us as we look to build the muscle memory within the health system is that this new framework will have those folks matched up with people who are very knowledgeable, the most knowledgeable about things like the funding formulas, like ways that you fund the adoption and diffusion of innovation so that we work together across the silos that exist along the patient journey for which we're looking for innovation and adoption.

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We also will be ensuring that people who do this type of work benefit from the experiences and the learning of the people who have come before them. That's not particularly earth-shattering, but exciting in that you will now have people looking to adopt and diffuse innovation systematically, if you will, or as an institutional memory, learning from who has gone before them and getting away from a situation where we depend on heroes, if you will, rather than processes for spreading good ideas about how to do innovation procurement—so do things differently and do innovative things.

Yes?

Ms. Ann Hoggarth: I just want to ask you a question before the time runs out. There's a company in Barrie, Southmedic, which has developed an oxygen mask that is used all over the world, but they can't get into the market here in Ontario because of large US companies. Also, there is a company that has made an MRI machine that is portable. I think that started in MaRS, actually. Are those the kinds of things you're talking about, that you'll be looking into?

Mr. William Charnetski: Very much so. In fact, I think the second company you're referring to is Synaptive Medical, led by Cam Piron and colleagues. We know Synaptive very well, and it's a perfect example. Remember I said a few minutes ago that there's no reason why the next big global company in health technology couldn't come out of Ontario? We think Synaptive is one of those. Their technology is world-leading and so exciting. They have now even relocated within Toronto—

Ms. Ann Hoggarth: Yes, I went to the reopening.

Mr. William Charnetski: With new facilities—not just with white-collar, if you will, jobs, but manufacturing facilities, if you can imagine. Down in the fashion district, you now have this company that has been described as having committed to Toronto with manufacturing facilities. In case you're wondering why, it's because those old fashion houses have the big elevator doors and massive elevators that allow things like MRI machines to be moved up and down. Who would have thought it? That's a great example of exactly the kind of work we're doing.

Those are the overarching priorities. As we look forward to digging into more work, I think you'll be pleased to know that we've chosen to focus on home and community care, so better care closer to home. How can digital, virtual and mobile technologies help make health delivery in that sector more effective and efficient? Digital health in particular: You'll hear about and you have heard about so many great things that digital technology can do. How do we ensure that those tools and collaborators in digital health are Ontarians—not to the exclusion of others, again, but certainly growing in that capacity.

Lastly, how do we improve health outcomes for indigenous people in the province? How do we have these exciting and life-altering technologies brought to those people?

I'll just finish with one thing, and maybe it's a great way, I'll say humbly. Quick, we—

The Chair (Ms. Cheri DiNovo): Sorry, we're out of time, so we have to move to Mr. Yurek.

Mr. Jeff Yurek: Thanks, Chair. Minister, 90% of long-term-care residents have some form of cognitive impairment, and one in three is severely impaired. Your last budget says that the government "is working towards the goal of a BSO resource in every long-term-care home in Ontario." The Ontario Long Term Care Association says that half the homes are still without a dedicated in-home BSO team. Do you have a timeline to reach this goal?

Hon. Eric Hoskins: This in an incredibly important resource: Behavioural Supports Ontario. You're absolutely right. Because of the increased acuity of residents of long-term-care homes, this becomes even more important—the Alzheimer's and other forms of dementia that we're seeing, among others. We increased, I believe

last year as well as this year—I know that this year we increased behavioural supports by $10 million, and now I think our annual expenditure is $64 million.

That is our goal. In fact, the announcement that the Premier made last week, as well, in part spoke to that investment and the increase in the hours of care, giving us the ability to invest even more in BSO and behavioural supports.

Bob, I'm not sure whether we have a specific target at this point, in terms of when to complete.

Dr. Bob Bell: No, we don't, Minister. I think we've got an aspiration to have a BSO care provider in every home, as you said, but I don't think that we have worked out the budget allocation that would allow that to happen.

Hon. Eric Hoskins: But I do know that this fiscal year, the investment that we announced through the budget allows us to hire an additional 150 specialized health care providers in that BSO field.

Mr. Jeff Yurek: Do you have a strategy for smaller, rural long-term-care homes to redevelop so that they aren't forced to amalgamate with other small homes?

Hon. Eric Hoskins: Yes, we do. This has been really important to me personally, and as minister, of course. Fortunately, we have a system where every redevelopment, every movement of a bed from its current premises, requires my signature and my approval. That gives me the ability to insert myself in some of these more delicate and challenging circumstances. I grew up in a small town of 10,000 people. I understand just how there's a different lens through which people look at these services, as they should. That issue of access is so important.

The announcement that was made last week of the 5,000 beds by 2022 enables us—which we have already been doing, in some instances. We've already made decisions, in terms of allocations, that will result in deciding against proposals coming from providers and operators of long-term-care homes that are proposing to move beds out of smaller communities. This allows us—and it is my intention—to provide that added flexibility. In some cases, if it requires the addition of additional beds to make the business case viable or to retain those beds in the local community, I will make that decision. So I'm confident, and it is one of my top priorities to work, together with the ministry, to ensure that we come up with those positive solutions that truly respect the local communities. Yes.

Mr. Jeff Yurek: With regard to MPP Gélinas's private member's bill, Time to Care Act, will a minimum standard be established to average four hours of care in our homes, at minimum?

Hon. Eric Hoskins: The Premier announced that last week. It's part of our seniors strategy.

I appreciate the hard work that the member from Nickel Belt put into specifically focusing on the hours of care and the staffing within long-term-care homes. Her work reflects the increased acuity that I was referencing earlier.

That is a commitment that we've made, to reach that average minimum, that average level of care of 4.0. It varies, of course, but I think we're at 3.5 currently, and we have committed to going to 4.0.

The Chair (Ms. Cheri DiNovo): Two minutes.

Mr. Jeff Yurek: Has the government looked at the issue I'm finding in my area of the province—I'm sure it's across the province—the fact that there's a whole subset of the population in their forties, fifties and sixties needing a long-term-care placement, but who shouldn't be in a long-term-care home with 80- and 90-year-olds? Have you looked at how the ministry is preparing for that increase in the population? I have really seen a spike in my area of people needing those spots.

Hon. Eric Hoskins: It certainly has been and is a challenge. Again, it varies, and it depends, often, on the level of community supports that might be available, or alternatives to long-term care. We strive to provide the most appropriate level of care in the right environment for individuals, but understand that often there are capacity challenges, or challenges with regard to an individual's specific and unique needs.

Currently, about 6% of individuals who reside in long-term-care homes are under the age of 65. I think we can imagine some of the circumstances that could lead to that. Acquired brain injury is often an example of an individual who is not a senior but who requires a higher level of care. We're working on how we might be able to address that in the most effective way.

The Chair (Ms. Cheri DiNovo): And with that, we stand adjourned. Thank you, everyone.

The committee adjourned at 1800.

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